

Minimum Value of an Employer-Sponsored Health Plan

Notice 2012-31

I. PURPOSE AND OVERVIEW

This notice describes and requests comments on several possible approaches to determining whether health coverage under an eligible employer-sponsored plan, as defined in § 5000A of the Internal Revenue Code (“employer-sponsored plan”), provides minimum value within the meaning of § 36B(c)(2)(C)(ii). Beginning in 2014, eligible individuals who purchase coverage under a qualified health plan through an Affordable Insurance Exchange may receive a premium tax credit under § 36B unless they are eligible for other minimum essential coverage, including coverage under an employer-sponsored plan that is affordable to the employee and provides minimum value. Under § 36B(c)(2)(C)(ii), a plan fails to provide minimum value if “the plan’s share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.” If the coverage offered by the employer fails to provide minimum value, an employee may be eligible to receive a premium tax credit. An applicable large employer (as defined in § 4980H(c)(2)) may be liable for an assessable payment under § 4980H if any full-time employee receives a premium tax credit.

The Treasury Department and the Internal Revenue Service intend to issue proposed regulations on determining minimum value and are considering incorporating the approach described in this notice. As described below, under anticipated future guidance, an employer-sponsored plan would be able to use one of several alternative approaches to ascertain that the plan provides minimum value. Specifically, this notice

seeks comment on the following three potential approaches that could be used to determine whether an employer-sponsored plan provides minimum value:

- The actuarial value calculator (AV calculator), referred to below, or a minimum value calculator (MV calculator) to be made available by the Department of Health and Human Services (HHS) and the Treasury Department. In either case, the calculator would permit an employer-sponsored plan to enter information about the plan's benefits, coverage of services, and cost-sharing terms to determine whether the plan provides minimum value. The data underlying the MV calculator (which would be designed for use by employer-sponsored self-insured plans and insured large group plans) are expected to be claims data reflecting typical self-insured employer plans.
- An array of design-based safe harbors in the form of checklists that would provide a simple, straightforward way to ascertain that employer-sponsored plans provide minimum value without the need to perform any calculations or obtain the assistance of an actuary.
- For plans with nonstandard features that preclude the use of the AV calculator or the MV calculator without adjustments, an appropriate certification by a certified actuary, in accordance with prescribed continuance tables, recognized actuarial standards, and other conditions that may be prescribed in administrative guidance, that the plan provides minimum value.

Section VI of this notice describes these potential approaches in greater detail.

Under the statute, certain of the rules for determining whether an employer-sponsored plan provides minimum value are to be based on forthcoming regulations to

be issued by HHS that will specify the methods for determining the actuarial value of a qualified health plan (QHP) offered through an Affordable Insurance Exchange and non-grandfathered plans in the individual and small group markets. On February 24, 2012, HHS issued the “Actuarial Value and Cost-Sharing Bulletin” (HHS actuarial value bulletin) describing the assumptions and methodology that HHS anticipates will govern the calculation of actuarial value.¹ (See <http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>.) This notice describes how guidance issued by HHS on the determination of actuarial value is expected to be applied in determining minimum value. This notice also outlines ways in which the determination of minimum value is expected to differ from the determination of the actuarial value of QHPs in order to reflect differences between QHPs and employer-sponsored plans, such as differences in their levels of standardization and the populations covered.

Employer-sponsored self-insured and insured large group plans are not required to conform their plans to any of the essential health benefit (EHB) benchmarks that HHS intends to propose to apply to QHPs.² These employer-sponsored plans need not offer all of the EHBs or even cover each of the ten statutory EHB categories.

This notice provides information regarding the actuarial value of existing

¹ The actuarial value rules under § 1302(d) and the essential health benefit provision under § 1302(b) apply to QHPs offered on an Affordable Insurance Exchange and also to non-grandfathered plans in the individual and small group insurance market. See § 2707(a) of the Public Health Service Act, as added by § 1201 of the Affordable Care Act, which provides that non-grandfathered plans in the individual and small group insurance markets must cover the “essential health benefits package,” as defined in § 1302(a) of the Affordable Care Act.

² The EHB benchmarks that HHS intends to propose also apply to non-grandfathered plans in the individual and small group insurance markets.

employer-sponsored plans (Section II) and the statutory background of the premium tax credit and the minimum value provision (Section III). The notice then describes, by way of background, the intended methodology laid out in the HHS actuarial value bulletin for determining the actuarial value of a QHP (Section IV) and explains the assumptions expected to be used to determine whether an employer-sponsored plan meets the minimum value threshold (Section V). The notice describes the options that are being considered for determining whether an employer-sponsored plan has an actuarial value of at least 60 percent and therefore provides minimum value (Section VI). Finally, the notice also invites public comments (Section VII).

II. ACTUARIAL VALUE OF EXISTING EMPLOYER-SPONSORED PLANS

The actuarial value of a health plan is a measure of the percentage of health care costs, on average, that the plan is expected to cover. A report issued last fall by HHS found that approximately 98 percent of individuals currently covered by employer-sponsored plans are enrolled in plans that have an actuarial value of at least 60 percent using methods and assumptions similar to those described in this notice for determining minimum value. (See Actuarial Value and Employer-Sponsored Insurance, ASPE Research Brief, U.S. Department of Health and Human Services (November 2011) <http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.shtml>.) The HHS report also concludes that four core categories of benefits and services are the greatest contributors to a health plan's actuarial value: physician and mid-level practitioner care; hospital and emergency room services; pharmacy benefits; and laboratory and imaging services. Because they account for only a very small portion of overall medical expenditures, benefits and services beyond these four core categories of benefits that

are covered by a plan generally have only a limited impact on the plan's actuarial value. For example, a plan that does not include coverage for rehabilitative services, durable medical equipment, acupuncture and chiropractic services, and home health services may have an actuarial value that is only 5 percent less than a plan that includes coverage for these services. (See ASPE Research Brief.) We seek input on whether other analyses using different data or assumptions produce similar or different results.

III. STATUTORY BACKGROUND

Section 36B was added by § 1401 of the Patient Protection and Affordable Care Act, Public Law 111-148, and modified by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (collectively, the Affordable Care Act). Beginning in 2014, certain taxpayers are allowed a refundable premium tax credit under § 36B to assist in purchasing QHP coverage through an Affordable Insurance Exchange. The premium tax credit is designed to make QHP coverage affordable by reducing an eligible taxpayer's out-of-pocket premium cost. (Under § 1402 of the Affordable Care Act, eligible individuals are entitled to an advance payment of the premium tax credit, which is paid directly to the QHP issuer selected by the individual.)

An employee, or a member of the employee's family, who is eligible to enroll in an employer-sponsored plan is not eligible for a premium tax credit unless the plan's coverage for the employee either is unaffordable, as defined in § 36B(c)(2)(C)(i)(II), or does not provide minimum value, as defined in § 36B(2)(c)(2)(C)(ii). An employee (or member of the employee's family) also is not eligible if he or she actually enrolls in the employer-sponsored plan, even if the plan is not affordable or fails to provide minimum value. Under § 4980H, an "applicable large employer" is generally liable for an

assessable payment if any full-time employee receives a premium tax credit.

To satisfy the minimum value requirement under § 36B(c)(2)(C)(ii), a plan's share of the "total allowed costs of benefits provided under the plan" must equal or exceed 60 percent of such costs. Section 1302(d)(2)(C) of the Affordable Care Act directs that the statutory phrase -- "percentage of the total allowed costs of benefits provided under a group health plan" -- is determined under rules contained in the regulations to be promulgated by HHS under § 1302(d)(2) (titled "Actuarial Value"). The requirements applicable to these HHS regulations are set forth in subparagraphs (A) and (B) of § 1302(d)(2).³ Consistent with these statutory requirements, the determination of whether an employer-sponsored plan provides minimum value will be based on the actuarial value rules with appropriate modifications.

Subparagraph (B) of § 1302(d)(2) requires HHS to issue regulations under which employer contributions to a health savings account (HSA) may be taken into account in determining the actuarial value of an employer-sponsored plan. In addition, § 1302(d)(3) of the Affordable Care Act authorizes the Secretary of HHS to determine a reasonable "de minimis" variation in the actuarial values used in determining the level of coverage of a plan to account for differences in actuarial estimates.

IV. HHS INTENTIONS WITH RESPECT TO ACTUARIAL VALUE FOR QUALIFIED HEALTH PLANS

The HHS actuarial value bulletin explains that, in accordance with the requirements of subparagraph (A) of § 1302(d)(2) of the Affordable Care Act, the

³ Subparagraph (A) of § 1302(d)(2) requires the level of coverage of a plan to be "determined on the basis that the essential health benefits described in subsection [1302](b) shall be provided to a standard population. . ."

actuarial value of QHPs offered through an Affordable Insurance Exchange (and of non-grandfathered plans in the individual and small group insurance markets) is determined by computing the ratio of (1) the total expected payments by the plan, computed in accordance with the plan's cost-sharing rules (deductibles, co-insurance, co-payments, out-of-pocket limits), toward the costs a standard population is expected to incur at standard pricing for EHBs; over (2) the total costs a standard population is expected to incur at standard pricing for the EHBs.⁴ This actuarial value is used to determine the "metal level" of a QHP (that is, platinum, gold, silver, or bronze). For example, bronze plans must have a 60 percent actuarial value.

HHS announced that it intends to make available to the public an AV calculator that could be used to determine the actuarial value of QHPs (and non-grandfathered plans in the individual and small group insurance markets). The AV calculator would be designed so that issuers would be able to input a limited set of information on the benefits provided under the plan, and the calculator would provide the actuarial value of the plan. The claims data underlying the AV calculator would represent the entire range of EHB benchmark benefits that states would be permitted to select.

Although HHS anticipates that the overwhelming majority of issuers of QHPs

⁴ On December 16, 2011, HHS issued the "Essential Health Benefits Bulletin," which outlined the approach HHS plans to use to define the EHBs. (See http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.) Under this approach, each state would have the flexibility to select a "benchmark plan" from a list of permissible options specified by HHS in the bulletin. The scope of benefits provided under the state-specific benchmark plan would determine the scope of EHBs for QHPs in that state. In addition, the EHBs must encompass the ten categories of benefits listed in § 1302(a) of the Affordable Care Act. If the benchmark plan in a state does not offer coverage in each of the ten categories, the bulletin provides an intended method for supplementing deficient categories of benefits so all QHPs in the state would include benefits in all ten categories. The bulletin also provides an intended method for determining the benchmark plan in a state if the state fails to make a selection.

would be able to calculate the actuarial value of their health plans using the AV calculator, HHS requested comments on whether a QHP issuer whose plan design does not fit into the basic AV calculator logic should be able to obtain an actuarial certification in limited circumstances. HHS is considering options to permit such QHP issuers to obtain an actuarial certification that the plan design fits into the calculator logic or to obtain an actuarial certification that adjustments to the AV calculator-produced value are appropriate.

The HHS actuarial value bulletin also states that HHS intends to permit a de minimis variation of plus or minus 2 percent (so that, for example, a bronze plan could have an actuarial value between 58 and 62 percent). The bulletin also provides that amounts contributed by an employer to an HSA or first made available to an employee under a health reimbursement arrangement (HRA) would be taken into account by the AV calculator. The intended method for accounting for these contributions is discussed further below.

V. ASSUMPTIONS TO BE USED IN THE MINIMUM VALUE DETERMINATION

As discussed above, an employer-sponsored plan provides minimum value if its actuarial value is at least 60 percent. For employer-sponsored plans in the small group market, minimum value must be determined using a method that is consistent with the actuarial value rules under § 1302(d) of the Affordable Care Act and HHS guidance provided under that provision. It is expected that whether an employer-sponsored self-insured plan or insured large group plan provides minimum value would be determined in a manner generally consistent with the rules proposed by HHS for the calculation of actuarial value for plans subject to the actuarial value rules under § 1302(d), with

appropriate modifications that reflect differences in the markets and also account for the fact that employer-sponsored self-insured and insured large group plans are not required to offer EHBs in each of the 10 categories. Accordingly, it is expected that the minimum value of an employer-sponsored self-insured plan and insured large group plan would be determined in the same manner as actuarial value under § 1302(b) of the Affordable Care Act, except that these plans might be valued using a comparison to claims data reflecting typical self-insured employer plans, which would be based on continuance tables⁵ published specifically for use by such plans.⁶ Moreover, employer-sponsored self-insured and insured large group plans, as noted above, are neither required to cover each of the categories of EHBs nor to conform their plans to any of the EHB benchmarks that HHS intends to apply to QHPs, but would be permitted to take into account all benefits provided by the plan that are included in any of the EHB benchmarks.

In addition, an employer-sponsored plan would be permitted to add to the plan's value the employer contributions to an HSA and amounts made available under an HRA using a method similar to the method used by QHPs that are offered through a SHOP Exchange, as defined in § 1311(b)(1)(B) of the Affordable Care Act.

A. Standard Population and Utilization

Section 1302(d)(2)(A) of the Affordable Care Act specifies that actuarial value is

⁵ A health insurance continuance table is a distribution of annual paid claims arranged in a format that shows the amount of claims paid at each increasing level of expenditure, adding up to the total amount of expenditures for a covered group of enrollees.

⁶ This use of claims data reflected in the continuance tables would be relevant only for the purpose of determining minimum value, and does not imply that a plan must provide a particular set of benefits.

computed based on the health expenses that are expected to be incurred by a standard population, rather than the population that a plan actually covers. For purposes of determining minimum value in a manner that meets this standard, it is expected that two types of continuance tables would be made available for use by employer-sponsored plans. First, as described in the AV bulletin, HHS intends to publish continuance tables based on claims representing the entire range of EHB benchmark benefits and population data for employer-sponsored and individual market plans, with permissible state or regional adjustments to the standard population, utilization and pricing. These continuance tables would be incorporated into the AV calculator and would be used by QHPs and employer-sponsored plans in the small group market. Second, to reflect the differences between the population covered by QHPs (and plans in the small group market) and the population covered by employer-sponsored self-insured and insured large group plans, HHS intends to publish continuance tables based on claims and population data for typical self-insured employer-sponsored plans. This second set of continuance tables would be incorporated into an MV calculator, which would be provided and could be used to calculate the actuarial value of an employer-sponsored self-insured plan or an insured large group plan. This set of continuance tables would not include claims or population data for plans that are required under the law to provide EHBs or to meet state benefit mandates.

B. Treatment of HSAs and HRAs in Calculating Minimum Value

As noted above, the HHS actuarial value bulletin provides a potential approach to the calculation of actuarial value for a high deductible health plan (HDHP) that is linked to an HSA, as defined in § 223, or a group health plan that is integrated with an HRA

described in Notice 2002-45, 2002-2 C.B. 93, and Rev. Rul. 2002-41, 2002-2 C.B. 75.

The HHS actuarial value bulletin says that HHS intends to propose that, in calculating the actuarial value of the combined HDHP and HSA or combined employer-sponsored plan and HRA, the calculation would assume that the employer contribution to the HSA or amount first made available under an HRA is used by the employee to pay for cost-sharing. Accordingly, an appropriate portion of these amounts would be credited to the numerator of the actuarial value calculation. This means that any current year HSA contributions and amounts first made available under an HRA could be used to determine the actuarial value of an employer-sponsored plan. Generally, the employer would receive the same credit for HSA contributions in the numerator of the actuarial value calculation as it would receive for the same amount of first-dollar insurance coverage. The same rule would apply for amounts first made available under an HRA. (See HHS actuarial value bulletin, "Treatment of Health Savings Accounts and Health Reimbursement Arrangements in Calculating Actuarial Value.")

Treasury and the Service intend to follow HHS's rules for including employer contributions to an HSA and amounts made available under an HRA in the value of an employer-sponsored HDHP combined with an HSA or an employer-sponsored plan combined with an HRA when calculating the actuarial value of an employer-sponsored plan for purposes of determining whether it provides minimum value.

VI. OPTIONS FOR DETERMINING MINIMUM VALUE

Under guidance to be issued by Treasury and the Service, and consistent with rules to be promulgated by HHS, employer-sponsored plans would be able to use any one of several tests to determine whether the plan meets minimum value. Comments

are requested on three potential approaches described below.

A. AV and MV Calculators

Under this option, employer-sponsored plans would be able to determine their actuarial value by entering information about the cost-sharing features of the plan for different categories of benefits into a calculator. As described in the HHS actuarial value bulletin (in the section entitled “Operational Method for AV Calculation Using Standard Data”), HHS intends to provide an AV calculator that QHPs and plans in the small group market could use to determine the actuarial value of their plans. In addition, HHS and Treasury intend to develop an MV calculator, into which an employer-sponsored self-insured plan and insured large group plan would be able to enter cost sharing information that would be similar in design to the AV calculator but based on continuance tables reflecting claims data of typical self-insured employer plans. As such, the data underlying the MV calculator would represent the range of benefits covered by self-insured plans.

A calculator generally would be used to make minimum value determinations by employer-sponsored plans that have standard cost-sharing features. An employer-sponsored plan would be able to input a limited set of information on the benefits offered under the plan and specified cost-sharing features (for example, deductibles, co-insurance, and maximum out-of-pocket costs) for the four core categories of benefits: physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits, and laboratory and imaging services. The calculator would also take into consideration the annual employer contributions to an HSA or amounts made available under an HRA, if applicable.

B. Design-Based Safe Harbor Checklists

Based on analysis and information provided by HHS, Treasury and the Service intend to issue guidance that would give certain employer-sponsored plans an easy means to determine whether a plan provides minimum value without using a calculator or performing any calculations and without the need for actuarial expertise. This alternative would provide an array of safe harbor checklists that employer-sponsored plans may compare to their plan's coverage. If the employer-sponsored plan's terms are consistent with or more generous than any one of the safe harbor checklists, the plan would be treated as providing minimum value.

The safe harbor checklists would be used to make minimum value determinations for plans that cover all of the four core categories of benefits and services and have specified cost-sharing amounts. Each safe harbor checklist would describe the cost-sharing attributes of a plan (such as deductibles, co-pays, co-insurance and maximum out of pocket costs) that apply to the four core categories of benefits and services.⁷ The guidance would provide several safe harbor options, including coverage equivalent to an HDHP combined with an employer-funded HSA, that would satisfy the MV requirement. An employer-sponsored plan providing the four core categories would be treated as providing minimum value if its cost-sharing attributes are at least as generous as any one of the safe harbor checklist options.

Treasury and the Service expect to release the safe harbor checklists when HHS and Treasury release the MV calculator.

⁷ Although employer-sponsored plans are not required to cover all four categories of coverage, it is anticipated that plans failing to cover these categories would not satisfy any of the design-based safe harbors.

C. Actuarial Certification

Neither a calculator nor the safe harbor checklists would be able to accommodate employer-sponsored plans with “nonstandard” features, such as quantitative limits on any of the four core categories of benefits (including, for example, a limit on the number of physician visits or covered days in the hospital). Under a third option, consistent with the options proposed in the HHS actuarial value bulletin, employer-sponsored plans with nonstandard features would be able to generate an initial value using a calculator and then engage a certified actuary to make appropriate adjustments that take into consideration the nonstandard features.

Employer-sponsored plans with nonstandard features of a certain type and magnitude would also have the option of engaging a certified actuary to determine the plan’s actuarial value without the use of a calculator. The actuarial value would be determined in such case in accordance with the Actuarial Standards of Practice established by the Actuarial Standards Board. The certified actuary would make this determination based on the plan’s benefits and coverage data and the standard population, utilization and pricing tables published by HHS in consultation with Treasury in the form of the continuance tables available for purposes of the valuation of employer-sponsored plans and consistent with applicable administrative guidance.

VII. REQUEST FOR COMMENTS

Comments are requested on issues to be addressed in guidance on determining minimum value for an employer-sponsored plan. Comments are requested on issues plan sponsors, issuers, and employers may face in evaluating plan designs that will

cover part or all of 2014, including suggestions for transitional relief for plan years that start before and end in 2014.

Comments are requested on the potential alternative methods for determining whether an employer-sponsored plan provides minimum value. Comments are specifically requested on the following points:

1. The AV calculator or MV calculator would permit sponsors and issuers of employer-sponsored plans to enter information reflecting the benefits they cover and the cost-sharing features relating to the four core categories of benefits. Comments are requested on whether and how the actuarial value initially generated by the AV calculator or the MV calculator could be adjusted to take into consideration other benefits provided under the plan. For example, how could benefits such as wellness benefits be added to the actuarial value initially generated by the AV calculator or the MV calculator to determine whether an employer-sponsored plan provides minimum value? Are there other examples of benefits that employer-sponsored plans cover today or are likely to cover that might not be captured by the MV calculator and, if so, are employer-sponsored plans that cover those benefits typically near 60 percent actuarial value or more likely to be well above 60 percent actuarial value?
2. As discussed above, employer-sponsored plans with nonstandard features, such as quantitative limits on the four core categories of benefits, would not be able to use the AV calculator or the MV calculator (without an adjustment) to determine whether the plan provides minimum value. Comments are

requested on nonstandard features within the four core categories that are sufficiently narrow that the AV calculator or the MV calculator could still be used without adjustment to determine whether a plan provides minimum value and on the quantitative limits that employer-sponsored plans commonly use today. Comments are also requested on other plan features that could require the plan to adjust the valuation generated by the AV calculator or MV calculator.

3. Comments are requested on the terms that should be included in the safe harbor checklists and the types of plans for which safe harbor checklists should be developed.
4. With respect to a possible independent actuarial value certification, comments are requested on standards and safeguards that should be applied to ensure that the plan meets the 60 percent actuarial value threshold for the minimum value determination.

Comments may be submitted in writing on or before June 11, 2012. Comments should be submitted to Internal Revenue Service, CC:PA:LPD:PR (Notice 2012-31), Room 5203, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044, or electronically to Notice.Comments@irs.counsel.treas.gov. Please include "Notice 2012-31" in the subject line of any electronic communications. Alternatively, comments may be hand delivered between the hours of 8:00 a.m. and 4:00 p.m. Monday to Friday to CC:PA:LPD:PR (Notice 2012-31), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW, Washington, D.C. All comments will be available for public inspection and copying.

FOR ADDITIONAL INFORMATION

For further information on this notice, call the Office of the Division Counsel/Associate Chief Counsel (Tax Exempt & Government Entities) at (202) 927-9639 (not a toll-free call).